FBMC
proven benefit solutions
P.O. Box 1878, Tallahassee, Florida 32302-1878

COMMONWEALTH OF VIRGINIA
July 1, 2005 - June 30, 2006

FLEXIBLE REIMBURSEMENT ACCOUNT ELECTION FORM

To enroll in or make changes to your Flexible Reimbursement Accounts (FRAs), you may complete this paper election form or enroll online at **www.dhrm.virginia.gov** and click on the EmployeeDirect link.

To start, or change your account, place the election amount for the plan year in Box 1. Enter the number of paychecks and revised deduction per paycheck for the remainder of the plan year in Boxes 2 and 3 of the appropriate account.

To discontinue participation, place a zero in Box 3 of the applicable account.

Social Security #	Agency Number

Name (Please Print) Last	First	MI	E-mail Address

Home Address	City	State	Zip

Daytime Phone	Home Phone	Date of Hire	Date of Birth	No. Pay Periods Per Year	Annual Salary
( )	( )				

ENROLLMENT STATUS ☐ MID-YEAR ELECTION CHANGE* ☐ NEW HIRE ☐ ANNUAL ELECTION PERIOD — Event Date

*Indicate the qualifying mid-year event you have experienced by checking the appropriate box on the back of this form.

Indicate the amount you wish to pay through tax-free salary deduction by completing the sections below.
Complete the worksheets provided in your Flexible Benefits Sourcebook before deciding on the amount.
If you have questions, consult your Flexible Benefits Sourcebook, Benefits Administrator or call FBMC Customer Service at 1-800-342-8017.

In Box #1 indicate the dollar amount you elect to contribute for the plan year.
In Box #2 indicate the number of regular payroll checks you expect to receive during the plan year. (If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year, based on your effective date.)
In Box #3 indicate the deduction amount per paycheck. (Note: if Box #2 times Box #3 does not equal box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding). For changes during the plan year, this amount will indicate the revised deduction.

MEDICAL EXPENSE FLEXIBLE REIMBURSEMENT ACCOUNT

For eligible medical expenses incurred by you, your spouse and eligible dependents.
[Minimum is $10 per pay period; Maximum allowable contribution is $5,000)

Box #1
Total plan year dollar amount from your worksheet _____

Box #2
Number of regular paychecks expected ÷ _____

Box #3
Deduction per regular paycheck
(Whole dollar amounts only) = _____

DEPENDENT CARE FLEXIBLE REIMBURSEMENT ACCOUNT

TAX FILING STATUS [PLEASE CHECK ONE]: Minimum is $10 per pay period

☐ Married, filing separately ☐ Married, filing jointly ☐ Single, head of household

Box #1
Total plan year dollar amount from your worksheet _____

Box #2
Number of regular paychecks expected ÷ _____

Box #3
Deduction per regular paycheck
(Whole dollar amounts only) = _____

IMPORTANT. I UNDERSTAND THAT:

- I hereby authorize my employer to reduce my gross salary before taxes are calculated by the total amount of annual salary reduction indicated above.
- Any amount remaining in any FRA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
- The funds in one FRA cannot be used to reimburse expenses covered by another FRA.
- Expenses for which I am reimbursed cannot be deducted on my income tax return.
- The funds in any FRA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.
- The amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment or file an approved change in status with the Benefits Administrator within 31 days of the event.
- I agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any FRA or my failure to sign or accurately complete this election form.
- I certify that: 1) I will only use my FRA to pay for IRS-qualified expenses and only for my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my Employer's plans before seeking reimbursement from my FRA, 3) I will not seek reimbursement through any other source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

Employee Signature	Date Signed

Benefits Administrator Signature	Date Signed

DO NOT WRITE BELOW THIS LINE — FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES

SUBMIT YOUR COMPLETED FORM TO YOUR BENEFITS ADMINISTRATOR IMMEDIATELY.

Qualifying Mid-Year Events

You may change a benefit election upon the occurrence of a qualifying event but only if your change is made on account of, and corresponds with, a change in status that affects your own, your spouse's or your dependent's coverage eligibility. Assuming that these general consistency requirements are satisfied, if the event affects eligibility for a particular coverage, a corresponding change can be made to the same type of coverage.

You must submit an enrollment action within 31 days of the event. The Benefits Administrator for your agency will determine if your Change in Status meets IRS regulations. If approved, your existing benefits will be stopped or modified (as appropriate) at the first of the month following the event.

Please check below which Change in Status event you have experienced below:

Employment Change that Affects Eligibility:

- ☐ Employee begins leave without pay or family medical leave
- ☐ Employee returns from leave without pay or family medical leave
- ☐ Spouse or covered child gains employer eligibility (including switching from part-time to full-time employment)
- ☐ Spouse or covered child loses employer eligibility (including switching from full-time to part-time employment)
- ☐ Spouse begins leave without pay
- ☐ Spouse ends leave without pay

Legal Marital Status Change:

- ☐ Marriage
- ☐ Divorce
- ☐ Death of spouse

Judgments, Decrees or Orders:

- ☐ Judgment, decree or order allowing another party to cover your child(ren)
- ☐ Judgment, decree or order requiring coverage of child(ren)

Medicare or Medicaid Change:

- ☐ Dependent gaining eligibility for Medicare or Medicaid
- ☐ Losing eligibility for Medicare or Medicaid

Number of Eligible Family Members Change:

- ☐ Birth
- ☐ Adoption
- ☐ Covered child ceases to be eligible (exceeds plan's age limit, marries, becomes self-supporting, etc.)
- ☐ Death of a covered child
- ☐ Permanent custody granted

Changes Due to Special Circumstances:

- ☐ HIPAA special enrollment due to loss of other group coverage
- ☐ Losing eligibility under another government-sponsored plan
- ☐ Employee or dependent moves in or out of a plan's service area

Cost and/or Coverage Changes:

- ☐ Day care provider or cost of day care change (for Dependent Care FRA only)
- ☐ Open Enrollment or significant change under an employer's plan